38 Universal health coverage and NCD prevention and control

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Universal health coverage (UHC) is a central part of the 2030 Sustainable Development Agenda and the WHO Global NCD Action Plan. Achieving UHC means that all people would have access to the health services they need, when and where they need them, without financial hardship. UHC includes health protection and promotion, as well as disease prevention, treatment, rehabilitation and palliative care, across the life-course.[1]

There will always be trade-offs in allocating resources between each of the UHC dimensions (i.e. population covered, services provided, and direct costs to patients) (Figure 38.1). What levels of coverage can be provided for the population? Or should more services be covered by enlarging the benefits package to include other health services and if so which ones? Or should cost sharing and fees for patients be reduced?

In addressing these questions, it is clear that UHC is more of a political than a technical construct, with governments having to make decisions and trade-offs across: (i) levels of taxation on income, salaries and goods, and levels of public sector financing to improve access to healthcare, promote population health, and more broadly improve social determinants of health (e.g. education,

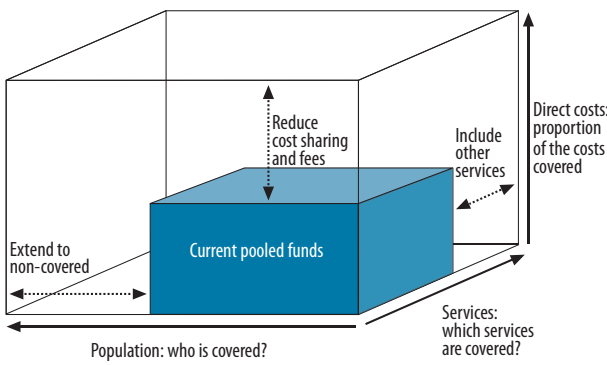

Figure 38.1 The three key dimensions of UHC: population coverage, service coverage and proportion of costs covered. World Health Report. Health systems financing: the path to universal coverage. WHO, 2010.

DOI: 10.4324/9781003306689-43

housing and social care – Chapter 17); (ii) the responsibility of government and the individual in accessing and financing the costs of healthcare, including the acceptable level of household out-of-pocket (OOP) expenditure (e.g. cost-sharing, self-medication and other expenses paid directly by households to the health provider) and the importance attached to preventing people from going into debt and as a result experiencing poverty and/or catastrophic health expenditure; and (iii) issues around levels of healthcare afforded to groups and communities that are marginalized or suffer from discrimination.

UHC poses important governance challenges,[2] including making decisions around health equity, social cohesion, the efficiency of resource allocation and sustainable human and economic development.[3] In this sense, the path to achieving UHC has been viewed as a political struggle and is not value-free.[4] The political importance of UHC was highlighted in 2019 when world leaders committed to ensuring UHC (including for the prevention and control of NCDs) was available in their countries.[5]

An effective health financing system is essential to achieve UHC. This consists of: (i) raising sufficient funding to cover the costs of the health system; (ii) pooling resources to protect people from the financial consequences of ill health; and (iii) purchasing or providing health services to ensure greater efficiency in the allocation of available resources. Most healthcare financing schemes receive transfers from the government, social insurance contributions, voluntary or compulsory prepayments (such as insurance premiums), other domestic revenues, and revenues from abroad (for example, as part of development aid and remittances). Chapter 39 provides more detail on financing for NCDs.

UHC and NCD outcomes

Key issues that those working on NCDs need to address include: (i) inadequate availability of and access to essential services for the prevention and the treatment of NCDs; (ii) inequalities in levels of NCD risk, access to services, and health outcomes; and (iii) the economic burden on national budgets and on individuals (including OOP payments for treatment and care, which can trap households and communities into a cycle of impoverishment and illness). Once accomplished, UHC can result in improved NCD outcomes, greater equity in access to services and enhanced socio-economic development.

As part of UHC, the following principles apply for the four NCDs considered in this compendium

- Comprehensive integrated healthcare across primary, secondary and tertiary care levels (e.g. investigation, treatment and continuum of care for high blood pressure [BP], diabetes, heart attack, stroke, chronic respiratory disease, asthma and cancer).
- Multi-sectoral action to address NCD risk factors (e.g. legislative action to prevent the advertising of tobacco products, taxation of tobacco, alcohol

and sugar-sweetened beverages), as well as decisions on earmarking these taxes for health and the underlying determinants of health.
- Engaging and empowering individuals and communities with their health and healthcare (e.g. food labelling to help promote a healthy diet, increasing health literacy around screening or health checks [e.g. diabetes, hypertension, cancer], and access to self-help groups).
- A life course approach.

Examples of how NCD responses can be improved as part of UHC include: (i) strengthening quality assurance (e.g. provision of quality-assured essential NCD medicines and technologies through improved quality control, procurement practices and regulation); (ii) reorienting health systems for chronic care (e.g. the use of existing service delivery platforms for issues requiring long-term follow-up, such as for HIV/AIDS and tuberculosis to introduce risk assessment, early diagnosis and management of NCDs, and ensuring that staff in these and other platforms are trained to take BP or blood glucose measurements, provide treatment for diabetes patients and provide information on ways of reducing NCD risk factors); (iii) strengthening systems for social care; and (iv) empowering communities, civil society and people living with NCDs (e.g. reducing stigma and discrimination experienced by people living with NCDs); and (v) empowering communities and patient networks to be able to claim their right to health and hold their governments accountable for delivering UHC.[6]

NCDs and UHC priority benefit packages

Average per capita health spending in OECD countries (which are mostly high-income economies) in 2019 (adjusted for differences in purchasing power) is estimated to be approximately USD 4,000 (ranging from almost USD 11,000 in the US to less than USD 2,000 in a number of countries).[7] As a result, most people living in OECD countries have access to a range of services through a publicly defined (even if not publicly funded) benefits package, with OOP spending as a share of final household consumption ranging from 1.3% in Turkey to nearly 5.8% in Switzerland.

However, most countries in the world are not in a position to provide the level of healthcare that the majority of OECD countries can enjoy. Where resources are most limited, prioritizing interventions is even more important. Priorities should be established on the basis of the health of the population (as a whole and for specific groups), interventions that maximize health gain and increase equity, a transparent understanding/assessment of resources available, and the views and preferences of the population.[8] Agreed priorities often come together in the form of an essential UHC priority health benefits package (UHC-PBP) that consists of health services, programmes, intersectoral actions, and fiscal policies that are considered necessary and affordable for a particular population, country or region. However, there is rarely consensus among countries on what constitutes a set of basic benefits beyond the narrowest priority benefit package.

NCD prevention, treatment and care at population and individual levels should be a key component of UHC-PBP in all countries. Tools to support the NCD elements of a UHC-PBP should include the best buys (Chapter 34) as well as a wider set of interventions provided in the interactive WHO UHC Compendium.[9] The web-based Compendium allows users to search for interventions by any NCD (or other disease), risk factor or through keywords, as well as for different stages across the life-course, and increasingly by the technical package (e.g. HEARTS, see Chapter 7).

The current Disease Control Priorities publication (DCP3) includes evidence on cost-effective interventions to address the burden of disease in low-income countries (LICs) and lower-middle-income countries. Each of DCP3's nine volumes defines a package of essential health measures containing both health-sector interventions and intersectoral policies. NCDs are covered in a volume on cardiovascular, respiratory and related disorders, with a second volume on cancer.[10]

Based on DCP3, estimates of minimal financial requirements for a UHC-PBP (including priority interventions for NCDs) have been developed for LICs and lower MICs. Modelled at 80% population coverage, these are USD 79 per capita each year for LICs and USD 130 for lower MICs.[11] Additional investments would require 8% (LICs) and 4% (lower MICs) of gross national income for 2015. DCP3 estimates indicate that a higher priority sub-package, with a reduced number of interventions, would cost approximately half of these amounts. Also, DCP3 estimates that cardiovascular, respiratory and related disorders account for 29% (LICs) and 36% (lower MICs) of the total healthcare cost, while cancer accounts for around 4% of these costs in LICs and 2% in lower MICs.

A series of steps are required to ensure that NCDs are incorporated into a country's UHC-PBP (Box 38.1).

BOX 38.1 STEPS TO ENSURE THAT NCDs ARE INCORPORATED INTO A COUNTRY'S UHC-PBP (ADAPTED FROM 12)

1. Align the NCD strategy with the National Health Sector Plan.
2. Engage relevant stakeholders in the UHC-PBP design process to:
   - Establish a list of priority NCD interventions using existing resources such as the best buys, local evidence and analysis, and tools such as the WHO UHC Compendium, WHO CHOICE (Chapter 34) and DCP3.
   - Estimate current and future costs of NCDs, interventions required and their return on investment (for example through investment cases that are described in Chapter 40).

- Set priorities for NCDs across health and other sectors, as well as communities.

3. Identify opportunities for financing NCD services:
   - Advocacy and development of measures to assess fiscal effort and projections of revenue (including macro-economic and demographic conditions for fiscal potential and health taxes).
   - Review of government funding priorities (fiscal space analysis, links to the investment plan, examination of evidence for efficiency with specific arguments to also develop interventions [e.g. for the prevention of NCDs] in non-health sectors).
4. Enforce implementation:
   - Development of monitoring and evaluation mechanisms to measure progress and to promote health equity.
   - Transparent communication to ensure that communities are aware of their entitlements, and service providers understand their responsibilities.
   - Design of transparent accountability and review processes.

An example of the process and outcomes of incorporating NCDs into Ethiopia's UHC-PBP is described in Box 38.2.[13]

BOX 38.2 REVISION OF THE ESSENTIAL HEALTH SERVICE PACKAGE (EHSP) IN ETHIOPIA

Process

- Over 2000 interventions were identified from the existing EHSP, national publications, WHO CHOICE database, DCP3 and consultations with experts.
- Prioritization criteria were developed based on disease burden, cost-effectiveness, equity, financial protection, budget impact, public acceptability and political feasibility as starting points.
- Expert evaluation of the recommended interventions were undertaken.
- Over 35 meetings were held with stakeholders over the entire process.

Outcomes for NCDs

- NCD interventions were aligned with WHO NCD best buys, with 31% of interventions focusing on cancer, 15% on policy and

behaviour change communications, 13% on cardiovascular disease and others, including chronic respiratory disease.
- NCD interventions were characterized as high priority (about 60%), medium priority (about 20%) or low priority (about 20%, which included mostly resource-intensive interventions).
- The EHSP focused mostly on primary healthcare centres and primary-level hospitals, with nearly 50% of NCD interventions at the primary healthcare level and 20% at the general hospital level.

A review of UHC-PBP in 45 LICs and lower MICs indicates that NCD interventions are increasingly prioritized. Nevertheless, only 2% of total development assistance for health was allocated to NCDs in 2018.[14]

Global partnerships

UHC2030 International Health Partnership.[15] UHC2030 is a global multi-stakeholder partnership for UHC which brings together countries and territories, multilateral organizations and global health initiatives, philanthropic organizations, NGOs (including those working on NCDs) and the private sector. It advocates for increased political commitment to UHC, facilitates accountability and promotes collaborative working on strengthening health systems.

The UHC Partnership.[16] This is one of WHO's largest platforms for international cooperation on UHC and primary healthcare (PHC). It comprises a broad mix of health experts working hand in hand to promote UHC and PHC by fostering policy dialogue on strategic planning and health systems governance, developing health financing strategies and supporting their implementation, and enabling effective development cooperation in countries, including revising and implementing UHC-PBPs.

DCP3 UHC Country Translation Project.[17] This partnership provides technical assistance and capacity building to low- and middle-income countries in revising and implementing national and sub-national UHC-PBPs.

Monitoring progress

Monitoring progress towards the SDG Target 3.8 (to achieve UHC, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all) is based, in principle, on all three dimensions of UHC noted at the beginning of this chapter: the extent to which the entire population is covered, the benefits package that is covered and the extent of financial protection attained for patients who access health services. In practice, monitoring to date has focused on the benefits package covered and the extent of financial protection assured.

Financial protection is assessed through the proportion of the population with large household expenditures on healthcare, as a share of total household expenditure or income. Two thresholds are used to define what is meant by 'large': >10% and >25% of total household expenditure or income. Household budget, household income and expenditure, and economic or living standards surveys (including demographic and health surveys) can all provide data for this indicator.

Health service coverage is assessed through 14 tracer indicators in the following categories: (i) NCDs; (ii) infectious diseases; (iii) reproductive, maternal, new-born and child health; and (iv) service capacity and access.[18] Indicators are measured through a range of surveys (household and health facility availability and readiness) and sentinel surveillance systems. There are three tracer indicators for NCDs:

- Prevention of CVD (age-standardized prevalence of non-raised BP among adults aged ≥18 years).
- Management of diabetes (age-standardized mean fasting plasma glucose among adults aged ≥18 years).
- Tobacco control (age-standardized prevalence of adults aged ≥15 years not smoking tobacco in the last 30 days).

The WHO and the World Bank 2017 Global Monitoring Report on UHC noted that at least half of the world's population does not have full coverage of essential health services.[19] The World Bank's 2018 Universal Health Coverage Study reviewed the experience of implementing UHC across 40 countries.[20] This work needs to be expanded to continue the drive for UHC and 'progressive universalism'.[21]

The authors gratefully acknowledge the valuable input and critical review provided by Joe Kutzin, WHO, Geneva.

Notes

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